

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVN13ADA	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/19/2009
NAME OF PROVIDER OR SUPPLIER ACTIONS OF ELKO		STREET ADDRESS, CITY, STATE, ZIP CODE 1297 IDAHO STREET ELKO, NV 89801		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	<p>Initial Comment</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.</p> <p>This Statement of Deficiencies was generated as a result of the State Licensure survey conducted at your facility on August 18, 2009 and August 19, 2009. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division.</p> <p>The facility is licensed for 13 residential program beds for the treatment of abuse of alcohol and drugs. The census at the time of the survey was four. Four resident files and eleven employee files were reviewed. One discharged resident file was reviewed.</p>	D 000		
D 217 SS=D	<p>NAC 449.141(9) Health Services</p> <p>9. Each facility shall maintain and have readily available first-aid supplies. Staff members shall have evidence that they have received training on the use of first-aid supplies.</p> <p>This Regulation is not met as evidenced by: Based on record review on 8/18/2009 to 8/19/2009, the facility did not ensure that 2 of 11 employees had evidence of first aid training (Employees #6 and #10).</p> <p>Findings include:</p>	D 217		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVN13ADA	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/19/2009
NAME OF PROVIDER OR SUPPLIER ACTIONS OF ELKO		STREET ADDRESS, CITY, STATE, ZIP CODE 1297 IDAHO STREET ELKO, NV 89801		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 217	Continued From page 1 Severity: 2 Scope: 1	D 217		
D 235 SS=F	NAC 449.144(4) Medication 4. Members of the staff may not administer any medication unless licensed to do so. This Regulation is not met as evidenced by: Based on record review and interviews from 8/18/2009 to 8/19/2009, the facility was allowing unlicensed staff to administer medications to 4 of 4 clients. This was a repeat deficiency from the 2/25/08 State Licensure survey. Severity: 2 Scope: 3	D 235		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.